MACRA AND THE MEDICARE PAYMENT REFORM JUGGERNAUT

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MACRA and the Medicare Payment Reform Juggernaut

More Changes Coming to Healthcare Delivery

The passage of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA)[1] has contributed to changes in healthcare delivery by redesigning Medicare's payment and delivery methods for physicians and other clinicians.

MACRA repealed the highly debated sustainable growth rate (SGR) formula which eliminates the 21 percent across-the-board cut in Medicare's provider payments. This legislation supports Medicare's efforts to move rapidly from the current fee-for-service (FFS) reimbursement model toward value-based payments for physician services.

Healthcare in the United States is in the midst of a financial and clinical overhaul driven by new legislation that attempts to improve outcomes and reduce costs. Reinventing our healthcare system across the entire care continuum and getting over 16 million healthcare workers[2] to follow new rules and regulations is about as complicated as putting a man on the moon. Luckily we were successful in that endeavor and we expect to be equally successful implementing healthcare's sweeping changes.

Industry leaders and policymakers have tried countless incremental fixes designed at improving care and reducing costs—but none has had much impact. In 2010, the catalyst for reform became law with the passage of the Patient Protection and Affordable Care Act also known as the Affordable Care Act (ACA).[3] The law established a Health Insurance Marketplace[4] designed to improve consumer access to affordable healthcare through private payers and provided strong financial incentives in publicly financed healthcare programs tying provider payment to quality of care and efficiency.

Building on the principles set by the ACA and the passing of MACRA, the Centers for Medicare and Medicaid Services (CMS) has targeted 30 percent of Medicare payments to be tied to the quality of care or value through alternative payment models by the end of 2016 and 50 percent by the end of 2018.

As our population ages, it is more important than ever to have the appropriate provider incentives in place to care for the almost 60 million Americans that are

eligible for Medicare today and the projected 80 million beneficiaries that are estimated by 2030.[4,5]

The MACRA Program

MACRA provides CMS the leverage required to drive quality measure development with the aim of providing patients with better care while spending more intelligently and improving clinical outcomes. With the passing of MACRA, there are five significant changes to the Medicare payment system:

1. Ending the sustainable growth rate formula;
2. Establishing a new framework for rewarding value;
3. Creating a built-in period of financial stability for providers;
4. Combining existing quality reporting programs into one system; and
5. Providing support for physician practice transformation.

The MACRA legislation is intended to advance CMS's goal for a value-based payment system. Called by CMS as the "Path to Value"[6] from 2015 through 2021 and beyond, MACRA allows healthcare providers to participate in one of two new quality incentive programs:

1. Merit-Based Incentive Payment System (MIPS)
2. Alternative Payment Models (APMs)

With MACRA, a new payment framework consisting of annual fee updates and incentives will be implemented for MIPS and APMs. The schedule for the program is:

- 1/1/2015 through 6/30/2015: 0 percent update
- 7/1/2015 through 12/21/2015: 0.5 percent update
- 2016 through 2019: 0.5 percent update each year (subject to MIPS adjustment beginning in 2019)
- 2020 through 2025: 0 percent update each year (subject to MIPS and APM adjustment)
- 2026 and beyond: Annual updates during this period consist of:
    1. A "qualifying APM conversion factor" for professionals participating in qualified APMs is set at 0.75 percent; and
    2. A "non-qualifying APM conversion factor" for all other professionals, set at 0.25 percent.

The Merit-Based Incentive Payment System (MIPS)

The MIPS[7] is a new program that combines parts of:

- Physician Quality Reporting System (PQRS);
- Value Modifier (VM) or Value-Based Payment Modifier (VBM);
- Medicare Electronic Health Record (EHR); and
- Medicare EHR Incentive Program for Eligible Professionals (EPs),

  commonly referred to as Meaningful Use.

The basis of the program has four fundamental attributes:

1. *Quality*: Includes existing measures for quality performance programs, in addition to new measures developed through notice and comment rulemaking by CMS, and actions used by qualified clinical data registries and population-based measures;

2. *Resource Use*: Includes measures utilized in the current VBM program, with additional enhancements based on public input. These refinements must ascertain specific clinical criteria and patient characteristics to include patients in care episode and patient condition groups for resource use measurement purposes. The process also must develop patient relationship categories and codes that distinguish the relationship with a physician toward a patient at the time of furnishing an item or service;

3. *Clinical Practice Improvement Activities (CPIA)*: Reflects professionals' efforts to improve clinical practice or care delivery resulting in improved outcomes that include at least the following:

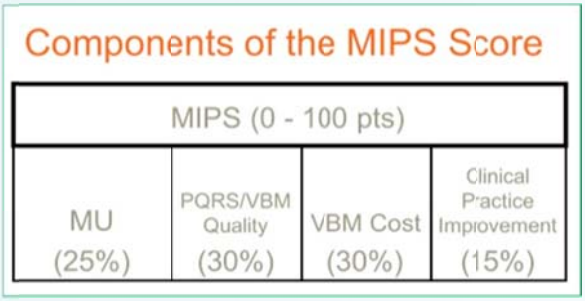
    1. Expanded practice access population management;
    2. Care coordination;
    3. Beneficiary engagement; and
    4. Patient safety and practice assessments in an alternative payment model.

4. *Meaningful Use (MU)*: Includes meeting current EHR MU requirements, as demonstrated by the utilization of a certified system.

The MIPS program that adjusts payments to providers is entirely voluntary. The fee-for-service[8] payment model is still available to those providers who want to follow it.

Beginning in 2017, MIPS will annually measure Medicare Part B providers in four performance categories to derive a "MIPS score" (0 to 100), which can

significantly change a provider's yearly Medicare reimbursement. The performance categories reflect the following:



MIPS measurements will be updated yearly through public notice, and the results are available on the CMS Physician Compare website. While it was not the intention of the program, making this data available to consumers is a giant leap in the right direction for more consumer transparency.

Those who are participating in the MIPS program will be eligible for positive, negative or no payment adjustments, plus an opportunity to be awarded additional incentive payment adjustments based on composite performance scores. Payment adjustment criteria are:

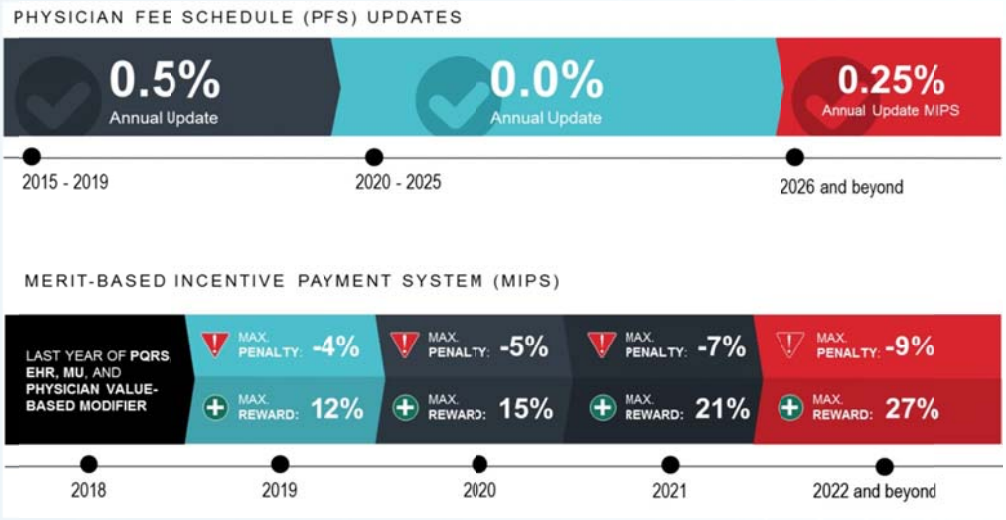
- *Positive Adjustments*: Eligible professionals whose composite performance scores are above the threshold will receive a positive payment adjustment, with higher performance scores receiving proportionally larger incentive payments. The magnitude of positive payment adjustments will vary and will maintain budget neutrality considering the amount of negative payment adjustments (except in certain limited circumstances), with a cap of three times the annual cap for negative payment adjustments.

- *Negative Adjustments*: The maximum negative adjustment will be as follows: four percent in 2019, five percent in 2020, seven percent in 2021, and zero percent in 2022 and subsequent years. The maximum negative adjustment will apply to eligible professionals whose composite performance score falls between zero and one-fourth of the performance threshold and smaller negative adjustments will apply to composite performance scores closer to the limit. Such negative adjustments will fund positive payment adjustments for professionals with composite performance scores above the threshold.

- *Zero Adjustments*: Composite performance scores at the threshold will receive no MIPS payment adjustment.

- *Additional Incentive Payment Adjustment*: An additional adjustment will be available for exceptional performance on a linear distribution basis, with better performers receiving larger incentive payments. The aggregated incentive payments will equal $500 million annually from 2019 through 2024.

The illustration below shows the milestones for payment updates and risk/reward compensation.



Source: Making Way for MACRA: Positioning Your Organization for Payment Reform, http://www.ecgmc.com/thought-leadership/articles/making-way-for-macra-positioning-your-organization-for-payment-reform

The Alternative Payment Models (APM)

MACRA provides incentive payments for EPs participating in certain types of APMs.[9] The program is for qualified providers who derive a significant portion of their patients and payments from APMs that include both risk for financial losses and quality measurement. MACRA requires quality measures used in APMs to be comparable to the quality measures used in MIPS.

Medicare defines any of the following as an APM:

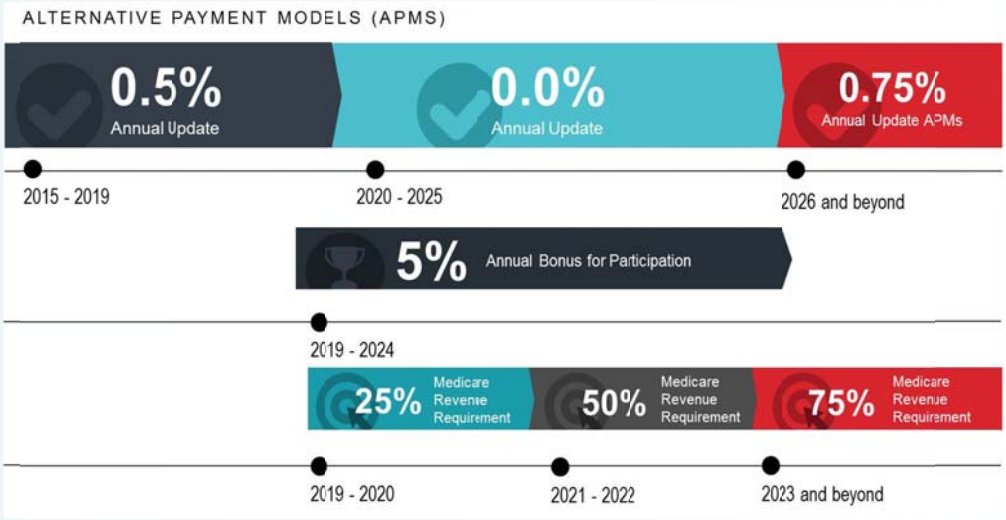
- An innovative payment model expanded under the Center for Medicare & Medicaid Innovation (CMMI), including Comprehensive Primary Care (CPC) initiative participants;
- A Medicare Shared Savings Program accountable care organization (ACO);
- Patient-centered medical homes and bundled payment models; and

- Medicare Health Care Quality Demonstration Program or Medicare Acute Care Episode Demonstration Program, or another demonstration program required by federal law.

Becoming APM-qualified isn't easy. Providers must meet additional qualifying principles for APMs. They require participants to meet all of the following criteria:

- Uses quality measures comparable to measures under the MIPS;
- Uses certified electronic health record (EHR) technology;
- Bears more than minimal financial risk OR is a medical home expanded under the CMMI; and
- Has increasing percentage of payments linked to value through Medicare or all-payer APMs.

The illustration below shows the timing of updates and revenue requirements for APMs.



Source: Making Way for MACRA: Positioning Your Organization for Payment Reform, http://www.ecgmc.com/thought-leadership/articles/making-way-for-macra-positioning-your-organization-for-payment-reform

If a provider chooses, they can opt to stay in the fee-for-service program until at least 2025. That said, CMS is encouraging industry stakeholders to move into the APM program because it incentivizes the delivery of value-based care. The difference between the fee-for-service program and APM model is:

Category One: Fee-for-service payment – no link to quality and value;

Category Two: Fee-for-service payment – link to quality and value; and

A. Foundational payments for infrastructure and operations

B. Pay for reporting
C. Rewards for performance
D. Penalties for performance

Category Three: APM built on quality and value fee-for-service architecture; and

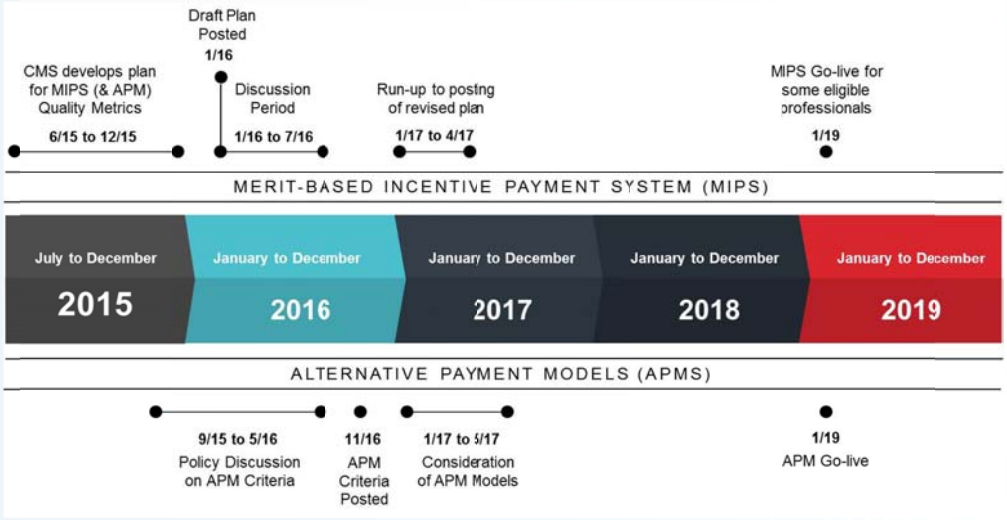
A. APMs with upside gainsharing
B. APMs with downside risk

Category Four: Population-based payment (future program); and

A. Condition-specific population-based- payment
B. Comprehensive population-based payment

MACRA Countdown to Go-Live

Many changes must occur before the 2019 go-live date. The illustration below compares high-level implementation milestones and timeframes of the MIPS and APM programs.



Source: Making Way for MACRA: Positioning Your Organization for Payment Reform, http://www.ecgmc.com/thought-leadership/articles/making-way-for-macra-positioning-your-organization-for-payment-reform

Before the kickoff of MACRA, the completion of many mandated tasks for measurement, development, processes, design and reporting must be in place, including:

- Policy discussion period for MIPS and APM;

- Consideration planning and measurement development;
- Reporting and financial adjustments; and
- Annual updating of program measures.

The Effects of MACRA for Providers and Healthcare Stakeholders

In his article, *Making Way for MACRA Positioning Your Organization for Payment Reform*,[10] Dave Wofford, a senior manager at ECG Healthcare Management Consultants, highlighted six areas that providers should consider between now and when MACRA kicks-off in 2019:

1. **Changes to CMS's payment methodologies for nonphysician services should be expected as well.**
   CMS's decision to measure and pay differently for physician resource utilization will affect costs in every setting where physicians provide services. Real changes in physician behavior regarding ordered services will transform services payment. We anticipate changes will begin to occur around 2022, once CMS has several years of data from this program.
2. **Understanding the relationship between Medicare Parts A and B will become more complicated.**
   Providers will need to become more sophisticated in understanding how performance under Part B—particularly the resource utilization incentive—will impact reimbursement under Part A. Therefore, providers must evaluate their Medicare strategy and participation in various programs (e.g., MIPS, APMs, Medicare Advantage) as it may not be effective simply to be a passive participant in Medicare FFS.
3. **Physician practice consolidation and acquisitions will continue.**
   Many smaller physician practices are unlikely to have the internal resources necessary to take full advantage of, and manage their performance against, MIPS or participate in an APM. This will likely accelerate consolidation into larger freestanding physician practices or integrated delivery systems. Additionally, given the impact that MIPS's resource utilization feature will have on hospital reimbursement, health systems may be even more motivated to employ physicians to shape their incentives appropriately.
4. **Physician compensation and service agreements will need to evolve.**
   Physician compensation arrangements, as well as professional services agreements, will need to include physician incentives that reflect those

being implemented by CMS. There will need to be a strategy to address the disparate performances from different physicians; certain physicians will have the potential for much lower or higher reimbursement rates. The question of who (i.e., the physician or the health system) bears the risk and reaps the reward will be a hot topic, especially considering the cost associated with ramping up technology capabilities for tracking the quality metrics built into MIPS.

While these changes will not happen overnight, they will begin to take place within just a few years. Therefore, assessing the implications of MACRA upon any long-term physician contracts that are currently in negotiation or up for renegotiation should happen shortly. If necessary, flexibility should be built into the contract language to accommodate future payment incentives.

5. **Commercial contracts will need to be amended.**
   Many commercial payor contracts contain language that defines reimbursement regarding a percentage of Medicare. While that has worked well in the traditional FFS world, it will not translate with the introduction of MIPS, and many commercial contracts do not have sufficient flexibility in them to accommodate this new feature. Therefore, commercial payor contracts should be reviewed to determine their compatibility with MACRA and language should be adjusted as necessary.
6. **Providers can have a voice in shaping the final product.**
   MACRA involves an extraordinary degree of delegation to CMS in fleshing out the details of the plan and it mandates that stakeholder input is considered in developing these finer points. Therefore, providers should take advantage of the opportunity to make their voices heard during the stakeholder comment and review process.

Summary

The passing of MACRA transcends the repealing of the SGR formula and signals the government's continued desire to evolve payment models that incentivize providers to improve patient care, reduce healthcare costs and make a significant step toward an industry-wide value-based payment system.

Healthcare leaders should stay ahead of the juggernaut of information by monitoring CMS' release of information detailing how the agency will implement MIPS and the APM incentive payments, including the creation of composite scoring criteria and performance thresholds.

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Phil C. Solomon serves as the Vice President of Global Services for MiraMed, a global healthcare revenue cycle outsourcing company and is the publisher of Revenue Cycle News, a healthcare business information blog. As an executive leader at MiraMed, he is responsible for creating and executing sales and marketing strategies which drive new business development and client engagement. Phil has over 25 years' experience consulting on a broad range of healthcare initiatives for clinical and revenue cycle performance improvement. He has worked with industry's largest health systems developing executable strategies for revenue enhancement, expense reduction and clinical transformation. He can be reached at phil.solomon@miramedgs.com or on Twitter @philcsolomon.